

Check One:
Dentist's pre-treatment estimate
Dentist's statement of actual services

AZ
DELTA DENTAL
Delta Dental Plan of Arizona
P.O. Box 43026
Phoenix, AZ 85080-3026

PATIENT COVERAGE INFORMATION
1. Patient name first m.i. last
2. Relationship to Member/Insured
3. Sex M F
4. Patient Birthdate MM DD YYYY
5. If full-time student, attach verification school city
6. Member/Insured name and mailing address
7. Member/Insured social security or I.D. number
8. Member/Insured birthdate MM DD YYYY
9. Group Policyholder (company) name and address
10. Group number
11. Is patient covered by another dental plan?
12-a. Name and address of Insurance carrier(s)
12-b. Group no.(s)
13. Name and address of other Policyholder(s)
14-a. Member/Insured name (if different than patient's)
14-b. Member/Insured social security or I.D. number
14-c. Member/Insured birthdate MM DD YYYY
15. Relationship to patient

I hereby accept the stated treatment plan and authorize release of any information relating to this claim.
Signature (Patient or Parent if Minor) X Date

BILLING DENTIST
16. Name of Billing Dentist or Dental Entity
17. Address
City, State, Zip
18. Dentist Soc. Sec. or T.I.N.
19. Dentist license no.
20. Dentist phone no.
21. First visit date current series
22. Place of treatment Office Hosp. ECF Other
23. Radiographs or models enclosed?
24. Is treatment result of occupational illness or injury?
25. Is treatment result of auto accident?
26. Other accident?
27. If prosthesis, is this initial placement?
28. Date of prior placement
29. Is treatment for orthodontics?
30. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Use charting system shown.
31. Narrative for unusual services

IDENTIFY MISSING TEETH WITH "X"
FACIAL
LINGUAL
PERMANENT
PRIMARY
RIGHT
LEFT
UPPER
LOWER
TOOTH # or letter
Surface
Description of Service
Date service performed
Procedure number
Fee
For administrative use only

I hereby certify that the procedures as indicated by date of service performed have been performed according to the provisions of the dental care plan named above.
Dentist Signature X Date
Total Fee Charged
Max. Allowable
Deductible
Carrier %
Carrier pays
Patient pays

OR CLAIMS AND BENEFIT INFORMATION, CONTACT:
SAISY (Delta's Automated Information System)
CUSTOMER SERVICE:
(602) 938-3131, ext. 1 (800) 352-6132, ext. 1 (602) 938-3131, ext. 2 (800) 352-6132, ext. 2

American Dental Association, 1990
9/97